

Remarks of
Chairman Henry A. Waxman
Subcommittee on Health and the Environment

at the
National Symposium on Schizophrenia
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Good morning. Thank you very much for this opportunity to speak to you. I'd like to focus my remarks today on Federal involvement in mental health services, and the future of financing for those and other health services.

Federal neglect of the mental health system is perhaps -- next to the budget deficit and the savings and loan debacle -- one of the most disturbing legacies of the Reagan/Bush Administration. To appreciate the current state of Federal support for mental health, let's look back at what happened over the last decade or so.

In the late 1970's Rosalyn Carter led a national campaign to promote community mental health services. In 1980, her efforts resulted in passage of the "Mental Health Systems Act." The Act was a bold, imaginative proposal which sought to expand the Federal government's commitment to mental health by providing the services needed through a system emphasizing community-based services. President Carter said the ultimate aim of the legislation was to assure that "all who need mental health services receive prompt care by qualified people, whatever their

need, wherever they may live, however they might come into the system.”

The ceremony signing the Mental Health System’s Act into law was held at a community mental health center in Annandale, Virginia. Mrs. Carter, who had served as Honorary Chairperson of the President’s Commission on Mental Health said enactment of the bill:

”represents a great victory for the vulnerable people in our society, those who are struggling with mental and emotional difficulties, and also it represents a victory for those people all over our country, dedicated professionals and private citizens who work every day to try to provide comprehensive, humane care for those who are vulnerable in our society.”

But with the election of Ronald Reagan, the Federal government’s commitment to improvements in the delivery of mental health services began to unravel. In fact, among the first acts of the Reagan Administration was to request repeal of the Mental Health Systems Act and establishment of a Health Services Block Grant. The block grant would have combined mental health funding with funding from nine other programs ranging from drug abuse treatment and home health to migrant health and black lung services. Total funding was to be reduced by 25 percent.

Although this proposal did pass the U.S. Senate, the House fought to retain the categorical nature of Federal mental health support. We were only partially successful. Although the Health Service Block Grant was never enacted, funding for mental health services was cut over 25 percent. A new state block grant was established combining funding for mental health and substance abuse services. This action marked the beginning of a decade-long erosion in Federal support for mental health services and a reordering of priorities away from service delivery and toward clinical and biomedical research.

In Fiscal Year 1980, Federal support of community mental health centers totalled \$324 million. Ten years later, Federal support for community mental health services through the Alcohol and Drug Abuse and Mental Health Services Block Grant totaled \$238 million, a 27 percent reduction -- without adjusting for inflation.

But funding reductions reveal only part of the story. The advent of the block grant fundamentally changed how the National Institute on Mental Health would view its role as an advocate and instigator of change.

Under the Mental Health Systems Act, NIMH was to be lead agency of reform. Today, with the exception of several small demonstration initiatives, NIMH has retreated to a role almost exclusively devoted to research.

Obviously research is important. It provides vital information necessary to improving the quality of treatment. One of our most important research priorities is trying to understand schizophrenia. As you know, this is a disease believed to afflict three million Americans and to cost society over \$40 billion each year to treat. NIMH currently spends over \$80 million on schizophrenia related research.

We know that mental illness is not limited to schizophrenia. Depression and affective disorders afflict 10 million Americans. Anxiety disorders are believed to afflict nine percent of adults. The mental disorders of aging, such as Alzheimer's disease, are a major concern in a nation in which the number of elderly is growing. This underscores the continued importance of a national investment in mental health research.

Historically, we have pursued a balanced approach to support of services and research. Today, however, Federal support for mental health research has expanded while Federal discretionary support for mental health services has shrunk. This represents a serious problem at a time when the demands placed upon the treatment system have skyrocketed.

I should note in passing that there have been some expansions in Medicare coverage for mental health services. In 1987, coverage for partial hospitalization services was added. In 1989, the annual dollar cap on outpatient mental health services was eliminated. That same year, coverage of services provided by clinical psychologists and social workers was added to the Medicare benefit package. While these expansions have helped Medicare beneficiaries, they obviously do not help the millions of individuals with serious mental illness who are not eligible for that program.

Ten years after enactment of the Mental Health Systems Act we are at a crossroads. There is ongoing debate about how active the Federal government should be in the mental health system since the overwhelming majority of current funding comes from State revenues. This past year an important step was taken which may represent a needed midcourse correction.

At the end of October, Congress passed and sent to the President a bill revising and extending the Stewart B. McKinney Homelessness Assistance Act. A major provision in this legislation is the creation of a new program to address the critical needs of homeless mentally ill . Seventy-five million dollars is authorized for each of the next four fiscal years. The National Institute of Mental Health is designated the agency to administer the program. If the President signs this bill, and if adequate funding is made available by the Appropriations Committees, this new program will represent the single largest increase in Federal discretionary support for mental health services in a decade.

Before turning to the agenda for the next Congress, let me briefly touch on one other issue that we dealt with this year that I know is of interest to many of you: Medicaid coverage for clozapine. As you know, this drug has been designated by the FDA as a breakthrough treatment for schizophrenia, and has been marketed by Sandoz since last February under the brand name Clozaril. The manufacturer has tied purchase of the drug to purchase of what it calls a patient monitoring system.

The recent Budget Reconciliation Act reforms the way in which the Medicaid program buys drugs, so that Medicaid will receive the benefits of price discounts for brand-name drugs that other large purchasers, such as the Department of Veterans Affairs and HMOs, now get. Under these reforms, manufacturers who enter into rebate agreements with the Medicaid program will be guaranteed access to the Medicaid market in every State for all their drugs.

There are a few exceptions to this, and one has to do with drugs like Clozaril in which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer. In the case of drugs with these tie-in arrangements, each State will have the option of denying coverage, even though the manufacturer has agreed to give rebates based on best prices for all of its other drugs.

I recognize that, if Sandoz does not change its marketing policy, this may result in denial of coverage for clozaril to some, perhaps many Medicaid beneficiaries. However, I want to assure you that this policy does not reflect any lack of concern on the part of Congress for Medicaid beneficiaries with schizophrenia. Instead, it reflects a much broader concern with the soaring prices of drugs in general, and with the potential of the tie-in arrangement exemplified by clozaril to further exacerbate this problem.

Drug prices have been a serious issue for many years but matters seem to be getting even more out of hand. It is no longer unusual for a drug treatment to cost \$1,000 per year. And we are seeing drugs that cost \$10,000 per year.

Now the drug companies are experimenting with a new device to increase drug prices -- linking the cost of the drug with other services that are necessary to minimize adverse drug reactions. Sandoz's drug Clozapine is the first drug to be marketed in the United States under this procedure. I have been informed that in Europe Clozapine costs between \$1,000 and \$2,000. But by adding the costs of monitoring, Sandoz charges approximately \$9,000 in the United States, far more than it would cost the patient or the health care system separately for the drug and the monitoring tests.

The Medicaid prescription drug reforms we just enacted will save the Federal and State government money and at the same time make important drugs available to poor people. However, we simply could not make this new open formulary requirement applicable to drugs such as Clozapine as long as the sale of the drug is linked to other services. To do so would place too great a burden on the States and would reward the inappropriate pricing behavior by a manufacturer.

I want to emphasize that the States are free to make Clozapine available through Medicaid, as was the case before the new reforms. And Sandoz now has the opportunity to force the States to make Clozapine available -- but only if it unties the drug from the monitoring services.

Let me conclude by looking forward to the next Congress, which will start in January. New initiatives will be considered by our Subcommittee to reestablish Federal leadership in improving the delivery of mental health services. I plan to introduce legislation to separate block grant funding for mental health services from block grant funding for substance abuse services. Establishment of a separate Block Grant will help States to provide community mental health services necessary to high priority groups such as seriously mentally ill children.

Even if we are able to enact such a program, the more basic issue is whether the Federal government will commit adequate resources to fund this and other initiatives. We have just enacted a Budget Bill that tightens up the Gramm-Rudman law even further, so that enactment -- and funding -- of new initiatives of any kind will be even more difficult. The Federal government obviously still has a serious deficit problem, and the competition for any new dollars that might become available will be intense.

One major issue will obviously be the uninsured -- a problem that will get worse if the economy slides into a recession. We have tried, on an incremental basis, to extend public and private coverage to more and more people over the years. We have had some success -- with pregnant women, with children, and with people laid off from their jobs. But the groups left out of the system -- those ineligible for Medicaid, the working poor, the chronically ill who can't get health insurance -- are clamoring for attention. And it is into this chorus that advocates for the mentally ill must add their voices.

The Pepper Commission, of which I am a member, proposed solutions to both the problem of the uninsured and the problem of long-term care in the report it released two months ago. I joined in the Commission's recommendations. I would note that among the Commission's proposals was that the basic benefits package to which Americans would be entitled would include mental health services, subject to 50 percent coinsurance.

The Pepper Commission Report is not a perfect document. It is a compromise. I believe that it outlines what is really the only politically viable solution to the crisis of the uninsured.

What are our choices? Basically, we have three:

- o a Canadian-style approach, using regional governmental payors
- o an employer-based approach, like the "pay or play" proposal of the Pepper Commission; or
- o tinkering with the current financing system by expanding Medicaid and reforming the small business insurance market.

If you look at the Pepper Commission report, you'll find that the employer-based approach reaches most of the uninsured without inordinately high Federal spending.

Tinkering with the current system is nearly as expensive but does not reach the majority of the uninsured.

A Canadian approach would reach all of the uninsured, and has the advantage of allowing the government to protect consumers from health care cost increases. But I do not believe that most Members are prepared to vote for the changes in our existing financing and delivery systems which this would require.

I do not mean to suggest that there is broad support at this time for the Pepper Commission's employer-based approach. But I do believe that, when they think about it, most Members will recognize that in order to address the problem of the uninsured we have to build upon the system we have now. And that system is a jobs-based system.

Of course, even if we are able to persuade the Congress to enact the Commission's reforms, we'll have to persuade the President to sign it.

The President has already walked away from his campaign promises to expand Medicaid coverage to all pregnant women and infants below 185 percent of poverty and to all children in families below 100 percent of poverty.

This past July, Secretary Sullivan gave a speech in Atlanta opposing a Canadian-style approach because it would, in his words, lead to "de facto rationing," and opposing a employer-based approach because it would, in his words, impose "overly burdensome mandates on business."

So we know what the Administration is against. The question is, what do you suppose they are for? As far as I can tell, what they are for is convening task forces to study the problem.

I don't believe that the American people will find this acceptable. The high cost of health care, the unaffordability of small business insurance, and the inaccessibility of basic health care for the uninsured are not problems that will fix themselves. They will only get worse, particularly if the economy goes into a recession.

Both the Congress and the President have a responsibility to address this crisis. However limited and shortsighted the results of this year's budget agreement, the problems will not go away. The challenge for you is to press for a solution that is comprehensive, and one that comes sooner rather than later. It is only with this kind of action that we will insure that the needs of all Americans, include those living the mental illness, are addressed.